

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS841S</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/11/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF LAS VEGAS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6151 VEGAS DRIVE LAS VEGAS, NV 89108</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments  This Statement of Deficiencies was generated as a result of complaint investigation conducted at your facility on August 11, 2009 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.  Complaint #NV00021922 was substantiated with deficiencies cited (See Tag Z 113). Complaint #NV00022643 was unsubstantiated. Complaint #NV00022721 was unsubstantiated. Complaint #NV00022725 was substantiated with deficiencies cited (See Tag Z 265). Complaint #NV00022739 was substantiated with deficiencies cited (See Tag Z 265).  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z 84 SS=E	NAC 449.74433 Assessment of Patient and Plan of Care  5. A comprehensive assessment must accurately reflect the physical, mental and psychosocial health of the patient. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure that admission assessments, nurse's notes, treatment Kardexes, and the Minimum Data Set accurately and consistently documented the skin condition for 5 of 10 residents. (Residents #4, #5, #6, #8, and #9)  Severity: 2 Scope: 2	Z 84		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z113	Continued From page 1	Z113		
Z113 SS=D	NAC 449.74439 Comprehensive Plan of Care  4. Services provided to a patient in a facility for skilled nursing must: a) Comply with the professional standards of quality applicable to those services; and b) Be provided by qualified persons in accordance with the patient's plan of care.  This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Huber needle was changed every seven days in accordance with a professional standard of nursing care for 1 of 10 residents. (Resident #2)  Severity: 2 Scope: 1	Z113		
Z265 SS=D	NAC 449.74477 Pressure Sores  Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient: 1. Who is admitted to the facility without pressure sores does not develop pressure sores unless the development of pressure sores is unavoidable because of the medical condition of the patient; and This Regulation is not met as evidenced by: Based on record review, the facility failed to prevent the development of a mid back pressure sore for 1 of 10 residents. (Resident #4)  Severity: 2 Scope: 1	Z265		

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